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HOUSE BILL 3135 By
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SENATE BILL 3279
By Rochelle

AN ACT to amend Tennessee Code Annotated, Title 56, relative to managed health care plans.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 32, Part 2, is amended by adding thereto the following new section to be appropriately designated:

56-32-2___.

(a) Contracts of coverage entered into by health maintenance organizations shall contain provisions assuring continuity of care so that persons who are new enrollees and who are under active care of a health care provider who is not under contract with the health maintenance organization may continue to receive care from such health care provider until the later of: (1) sixty (60) days from the enrollee's effective date in the health maintenance organization, or (2) if the enrollee is hospitalized on the enrollee's effective date in the health maintenance organization, sixty (60) days from the end of such hospitalization. If the enrollee is under care for pregnancy on the date of enrollment, the continuity of care requirement created by this subsection shall extend through delivery and medically necessary postpartum care.

(b) Every contract of coverage entered into by the health maintenance organization shall contain provisions assuring continuity of care so that enrollees

who are under active care of a health care provider who is deselected by the health maintenance organization may continue to receive care from such health care provider until the later of: (1) sixty (60) days from the date that the health care provider is deselected; or (2) if the enrollee is hospitalized on the effective date of the health care provider's deselection, sixty (60) days after the end of such hospitalization. If the enrollee is under care for pregnancy by the health care provider who is deselected, the continuity requirement established by this subsection shall continue through delivery and medically necessary postpartum care.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 32, Part 2, is amended by adding thereto the following new section to be appropriately designated:

(a) Every health maintenance organization (hereafter referred to as "plan") shall provide an independent review process to examine the plan's coverage decisions for individual enrollees who meet the following criteria:

(1) The enrollee has been denied coverage based on a determination by the plan that the proposed service or treatment does not meet the definition of "medical necessity" (or a similar coverage definition) set forth in the enrollee's evidence of coverage under the plan; the service or treatment is not considered experimental or investigational by the plan; and the proposed service or treatment would be a covered benefit; except for the plan's determination that the service or treatment does not meet the definition of "medical necessity" (or a similar coverage definition);

(2) The enrollee is a member of the plan in good standing, and is otherwise eligible to receive covered benefits under the health plan;

(3) The enrollee has complied with the appeals procedures described in the evidence of coverage and disclosure form under the plan and has requested

review and reconsideration by the grievance review committee pursuant to Section 56-32-210; and

(4) The proposed service or treatment would require the plan to incur one thousand dollars ($1,000) or more of expenditures to cover such service or treatment.

(b) The independent review process shall meet the following criteria:

(1) The plan shall offer all enrollees who meet the criteria in subsection (a) the opportunity to have the coverage denial reviewed under the independent review process. The plan shall notify eligible enrollees in writing of the opportunity to request the independent review at the time of the final appeals decision to deny coverage. The enrollee may file a request for independent review with the plan no later than sixty (60) days after receiving such notification.

(2) The enrollee shall be required to pay a one-time fee of one hundred dollars ($100) toward the cost of the independent review, payable at the time the enrollee requests the independent review.

(3) The plan shall provide to the independent review entity a copy of the following documents within five (5) business days of the plan's receipt of a request by an enrollee or enrollee's physician for an independent review:

(A) Any information that was submitted to the plan by the enrollee or the enrollee's physician in support of the enrollee's request for coverage under the plan's appeals procedures. The confidentiality of any medical records submitted by the plan shall be maintained pursuant to applicable state and federal laws.

(B) A copy of the contract provisions upon which the denial of coverage was based, any other relevant documents used by the plan in determining whether the proposed service or treatment should be

covered, and any statement by the plan explaining the reasons for the plan's decision not to provide coverage for the proposed service or treatment. The plan shall provide, upon request, a copy of documents required by this subparagraph, except for any legally privileged information, to the enrollee and the enrollee's physician. The independent review entity shall maintain the confidentiality of plan information identified as proprietary.

(4) The independent review entity shall notify the enrollee and the enrollee's physician of any additional medical information required to conduct the review within five (5) business days of receipt of the documentation required under paragraph (b)(3). The plan shall be notified of this request. The enrollee and the enrollee's physician shall submit the additional information, or an explanation of why the additional information is not being submitted, to the independent review entity and the plan within five (5) business days of the receipt of such a request. The plan may, at its discretion, determine that additional information provided by the enrollee or the enrollee's physician justifies a reconsideration of its coverage denial, and a subsequent decision by the plan to grant coverage shall terminate the independent review upon notification to the independent review entity. The enrollee shall be entitled to any refund of payment required under paragraph (b)(2) should the independent review be terminated under this paragraph.

(5) The independent review entity shall submit the expert determinations to the plan, the enrollee, and the enrollee's physician within thirty (30) days of the receipt of the request for review, except that for life-threatening conditions, as determined by the enrollee's physician, the determinations shall be submitted within seven (7) days of the receipt of the request for review. At the request of

the expert, the deadline shall be extended by up to five (5) business days for the consideration of additional information requested under paragraph (b)(3).

(6) The expert's determination shall be in written form and state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage. The expert shall make determinations based on the applicable coverage documents, including any defined terms that are provided for thereunder, such as "medically necessary", and shall not expand the contractually agreed upon coverage. The expert's determinations shall specifically cite the relevant provisions in the evidence of coverage, the enrollee's specific medical condition, and the relevant documents provided pursuant to paragraph (b)(3), to support the expert's determination.

(7) The determinations of the expert reviewer shall be binding on the plan and the enrollee. A determination in favor of the plan shall create a rebuttable presumption in any subsequent action at law that the plan's coverage determination was appropriate.

(8) The plan shall have written policies describing the independent review process. The plan shall disclose the availability of the independent review process and how enrollees may access the review process in the plan's evidence of coverage and disclosure forms.

(9) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the plan. Nothing in this subdivision shall be construed to require the plan to pay for the services of a non-participating physician, that are not otherwise covered pursuant to the evidence of coverage under the plan.

(c) Plan may contract with only those independent review entities meeting the following requirements:

(1) Expert reviewers assigned by independent review entities must be physicians or other appropriate providers who meet the following minimum requirements:

(A) expert in the treatment of the enrollee's medical condition, and knowledgeable about the recommended service or treatment through actual clinical experience;

(B) hold a non-restricted license in a state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area(s) appropriate to the subject of review; and

(C) have no history of disciplinary actions or sanctions (including, but not limited to, loss of staff privileges or participation restriction) taken or pending by any hospital, government or regulatory body.

(2) The independent review entity shall not be a subsidiary of, nor in any way owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers.

(3) Neither the expert reviewer, nor the independent review entity, has any material professional, familial, or financial conflict of interest with any of the following:

(A) The plan;

(B) Any officer, director, or management employee of the plan;

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment;

(D) The institution at which the service or treatment would be provided; and

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the enrollee whose treatment is under review.

(4) The term “conflict of interest” shall not be interpreted to include a contract under which an academic medical center, or other similar medical research center, provides health services to plan enrollees, except as subject to the requirement of subparagraphs (c)(3)(D); affiliations which are limited to staff privileges at a health facility; or an expert reviewer’s participation as a contracting plan provider where the expert is affiliated with an academic medical center, or other similar medical research center, that is acting as an independent review entity under this section.

(5) The independent review entity shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts; and the confidentiality of medical records and review materials.

(d) An independent review entity and an expert reviewer assigned by the entity to conduct a review under this section is not liable for damages arising from the determinations made pursuant to this section. This subdivision does not apply to an act or omission of the independent review entity that is made in bad faith or that involves gross negligence.

SECTION 3. Nothing in this act shall affect or apply to managed care organizations participating in the TennCare program.

SECTION 4. This act shall take effect January 1, 1999, the public welfare requiring it.